KAN Be Healthy (EPSDT) Screening Form

I.D. Number: _____

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T _____ **Weight** _____ (lbs/kg) _____ th% **Weight/Length** _____ %

P _____ **Length** (Birth to 36 months) _____ cm/in **Standing Height** (2 - 20 years) _____ cm/in

R _____ **BMI** _____ _____ th%

BP _____ BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

Head Circ (≤ 24 months) _____ cm/in _____ th%

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.

☐ No changes in medical Hx unless indicated.

☐ Previous Hx reviewed from _____ visit.

☐ Patient currently in Foster care, no previous hx available.

Present Concern: _____

Medications: _____

Serious Illness/Accidents: ☐ No ☐ Yes (date & type)

(including Hospital or ER visits)

Allergies (food & drug) _____

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐ Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

Allergies (food & drug)		Drug or ETOH Abuse		Mental Illness	
Asthma		Earaches		Obesity	
Birth defects		Epilepsy/Seizures		Scoliosis/Arthritis	
Blood Disorder/ Sickle Cell		Headache		Speech, Visual, Hearing	
Cancer		High Blood Pressure		Ulcers/Colitis	
Colds/sore throat		Kidney/Liver Disease		Urinary/Bowel	
Diabetes		Lung Disease		Heart Disease/Stroke	

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	
Cardiovascular	☐	☐	
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Last eye exam date: _____ Eye tracking (< 4 yrs old) Pass ☐ Refer ☐ Comments:_____

Corneal Light Reflex Present:Yes ☐ No ☐ Distance Acuity(4-20 yrs) Tool used:_____ Score: Left____ Right___ Both___

Outer Inspection: Normal ☐ Abnormal ☐ Near Acuity(4-20) Tool used: :_____ Score: Left____ Right___ Both___

NUTRITION

☐ WIC participant

☐ Referred to WIC

☐ Breast Feeding ☐ Formula

Amount & how often: _____

Number of Servings per day

Bread/Cereal _____ Dairy _____

Fat/Sweet/Sugar _____ Fruit _____

Meat/Bean/Egg _____ Vegetable _____

Fluid Intake: water _____ oz. Soda _____

Milk _____ oz. Juice _____

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside

☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)

☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No

If "yes", then complete following :

1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No

Referred to:

LABORATORY

HGB or HCT(required at 12 mths, start of menses in girls, 11-20 yr in boys)

HGB results:_____ or HCT results:_____Date obtained:_____

WIC results?: Yes ☐ No ☐ Date:_____ Other Lab?_____

IMMUNIZATIONS

Copy of record in chart

Current ☐

Behind ☐

Unknown ☐

Requested from Parent ☐

Referred to VFC provider ☐

Needs: (circle)

HepB DTaP Flu

Hib IPV MMR

MCV4 MPSV4 PCV

Varicella HepA

Other:

DEVELOPMENTAL / EMOTIONAL

Developmental Screening Tool: (required for all children < 6 yrs of age)

Tool Used (in file): _____

Results Pass ☐ Delayed ☐

Not Screened (Comments Required)_____

Interpretation of screen: _____

Referred to :

Developmental Emotional Observations or Tool: _____**(Age 6-20 yrs)**

Sleep Habits _____ Tired / overactive? _____

Discipline: _____ Vocational concerns? _____

Peer Interaction: _____

Grade Level _____ Average Marks _____

Special Education/Needs: _____

Any emotional or behavioral problems? _____

Emotional Observations:_____

DENTAL

Sees Dentist? Yes ☐ No ☐

Last dental exam date: ____/____/____

times brushes/day: _____

Dental Referral (annualy at a minimum 0-20yr)

Yes ☐ No ☐

HEARING SCREEN

Minimally must document completion and findings of paper hearing screen or audiometric sweep screen

Hearing Health History ≥ 5: Pass ☐ Refer ☐

Risk Indicators for Hearing Loss < 5 Pass ☐ Refer ☐

Hearing Developmental Scales < 5 Pass ☐ Refer ☐

Audiometric Sweep Screen: Left_____ Right_____

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline	5. Family Planning	9. Parenting	13. Self Breast Exam
2. Oral /Dental	6. Immunizations	10. Safety/Poisions	14. Sexuality
3. Development	7. Lifestyle	11. Substance Abuse	15. Exercise
4. Physical Activity	8. Nutrition	12. Self Testicular Exam	16. Weapon Safety

17. Other:_____

RESULTS/PLAN OF CARE

Screening Results: _____

Plan/Referrals (dental, vision, hearing, dietary, etc):_____

Recommended:_____

Return Date: / /

Parent/caregiver informed of KBH screen findings and verbalizes understanding of teachings.

Yes ☐ No ☐

Date: / /

Screening Providers Signature: _____

(Licensed Physician, ARNP , PA, or Registered Nurse trained to perform KAN Be Healthy screens)

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